SB 553 – CFI Subcommittee Work Groups

March 16, 2017

CFI Subcommittee Work Groups

I. Beneficiaries Protection (Cindy Roberts)
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   - B. Case Management
   - C. Grievance and Appeals
   - D. Office of Ombudsman
   - E. Enrollment
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II. Eligibility Group (Jebb Curelop)
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   - C. Prior Authorization
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III. Provider Services (Doug McNutt)
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   - D. Finance and Reimbursement
   - E. Credentialing
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IV. Quality/Outcomes/Transition (Tina Paquin)
   - A. Rates and Payments
   - B. Quality Outcomes
   - C. Quality Measures
   - D. Transitions – into Managed Care
   - E. Case Management

Beneficiaries Protections – Cindy Roberts

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Eligibility Group – Jebb Curelop

Jebb Curelop
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Considerations	Recommendations	Standards	Impac
Eligibility • Length of time for eligibility determination • Gaps in eligibility caused by overdue redeterminations • Lapses result in the member reverting to fee for service (FFS) and resuming with the MCO the following month. • Clinical and financial redeterminations are not necessarily simultaneous, resulting in two different points of potential lapse. • Checking daily for eligibility is burdensome to providers.	• DHHS to continue to determine eligibility for Medicaid and CFI • Retain the language currently in Appendix B-3 b. and f., which state that there is no waiting list for the CFI program. • Create an eligibility determination timeline and track (45 days) • Synchronize clinical and financial eligibility. • Maintain MCO enrollment and coverage for full months rather than allowing an eligibility lapse result in the member's coverage moving to FFS once reinstated. • Case management involvement: • After the DO/SLRC processes an application to the CFI program, a rotation process will be used to assign a case management agency for eligibility assistance. • The case manager will assist the applicant throughout the eligibility process, which may include both Medicaid and the clinical eligibility assessment required for CFI eligibility. • Eligibility assistance will be paid under targeted case management from the date individual was assigned to the case management agency and is eligible. • This process will ensure efficiency of the eligibility process.		

Considerations	Recommendations	Standards	Impact
	• Case Manager has a copy of the completed MEA before first home visit (this would be an advantage of case management involvement starting with the point of application) • Dedicated DFA/DCS eligibility staff to specialize in processing applications and manage transitions to ensure prompt reinstatement of CFI eligibility post discharge from hospitals and NFs. • Allow all parties to see the member's redetermination dates and status. • Establish the ability for more than one provider to create a member roster from NHts/NHEasy. • Clinical assessments will be completed through face to face meetings with applicants/members and others as preferred by the applicant, as follows: • The initial clinical assessment will be completed as required by 151-E:3, which does not limit the professionals performing assessments to RNs. • A service assessment is completed once eligibility is established to determine the types/amounts of CFI services may most directly meet the member's needs, and is completed using a single standard tool. • The service assessment tool will be developed collaboratively by DHHS, case management agencies and MCOs.		

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	• The same service assessment tool will be used by all MCOs. • The service assessment tool will be completed and submitted to the appropriate MCO electronically. • Assessment requirements will be established in the DHHS administrative rule. • Care plans developed by the case manager will: • Have the elements defined in the administrative rule, including an acknowledgement signature from the member or legal representative. • Be standardized across all case management agencies and MCOs. • Be electronic. • Electronic practice standard for sharing information (data, service auths and utilization), • Year 1: Data points will be shared between MCOs and Agencies. • Year 2: Case Management agencies should have access to the person's MCO health record so that all aspects of their health care can be considered in the development of the Care Plan. • Ongoing: continue to develop standards and methods for electronic communication between MCOs and CMAs. Explore the applicability of Consolidated-Clinical Document Architecture.		

Considerations	Recommendations	Standards	Impact
Transportation • Lack of consistency in drivers for recurrent trips (including for Adult Medical Day services) • Lack of consistent communication (sometimes CTS will ask that the member or family member call for the ride instead of the agency staff) • Inconsistent authorization times- 3 months, 6 months ,one year (AMD) • Pick up and drop off times not always accurate, resulting in home care staff requiring additional time while waiting for the driver. • Transportation home from the hospital not always available. • Transportation for last minute trips that might help avoid ER use, such as to Urgent Care or the doctor's office, are not always available. Transportation Current State Concerns • Lack of consistency in drivers for recurrent trips (including for Adult Medical Day services).	• Establish standards and reimbursement that supports service delivery, for: • Emergency transportation. • Urgent transportation. For example, TN uses "required for an unscheduled episodic situation in which there is no threat to life or limb but enrollee must be seen on the day of the request." • Escort Services for people who needs assistance • Curb to curb, door to door, hand to hand (such as assisting a person with dementia who is going from and AMD to their residence and caregiver). • Routine/other transportation. • Non-medical transportation (within CFI) as approved in the member's care plan. • Require an adequate transportation network. (needs definition) • Establish acceptable time frames for scheduled rides, for example: • The member will not arrive more than 60 minutes early for an appointment and waits no more than 60 minutes after the appointment for a ride home.		

Considerations	Recommendations	Standards	Impact
	• Compliance monitoring will include wait times. • Improve coordination amongst hospital discharge staff for rides home. • Develop the ability to pay home care staff for time and mileage to medical appointments. • Establish a consistent transportation provider and driver for approved recurrent trips, such as to Adult Medical Day. • Allow standing orders for transportation for recurrent trips, such as daily to AMD, or to dialysis.		

Provider Services – Doug McNutt

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Considerations	Recommendations	Standards	Impact
Provider Support	Provide for a Provider Claims Educator specific to LTSS who is located in New Hampshire and facilitates the exchange of information between the Grievances, Claims processing, and Provider relations systems. The primary functions of the LTSS Provider Claims Educator are to:	MCO contract with State State monitoring	Quality Services and adequate system
	Educate contracted and non-contracted Providers (e.g. HCBS Providers and Participant-Directed Services Providers) regarding appropriate Claims submission requirements, coding updates, electronic Claims transactions and electronic fund transfer, and available MCO resources such as Provider manuals, website, fee schedules, etc.		
	In the enrollment process the Educator shall:		
	1. Give clear direction regarding applications/documentation that need to be filed with DHHS and/or each MCO.		

Considerations	Recommendations	Standards	Impact
Provider Support (cont'd)	2. Distribute a checklist of requirements, including what needs to be an original document/signature, vs. faxed or electronic.		
	3. Communicate a timeline for how long it will take to process their enrollment application.		
	4. Each Claims Educator is the single contact at each MCO who can help them shepherd their enrollment application through the application/credentialing/ contracting process.		
	5. The Claims Educator shall be required to give providers timely notification – preferably electronic -- if the application is lacking documents, in order to avoid lags in the enrollment process.		

Considerations	Recommendations	Standards	Impact
Specialized skills and qualifications	Each MCO shall demonstrate that they have the staff or contract in their network to provide supportive employment Services.	In contract with State In State rules	Promote independence and quality of life
Communication	Interface with the MCO's call center to compile, analyze, and disseminate information from Provider calls. Provide monthly reports to Department on calls and resolution.	In contract with State	Assures quality
	Identify trends and guide the development and implementation of strategies to improve Provider satisfaction. Provide quarterly reports to Department on corrective actions for the improvement of Provider satisfaction.		
	Communicate frequently (i.e., telephonic and on-site) with Providers to provide for the effective exchange of information and to gain feedback regarding the extent to which Providers are informed about appropriate claims submission practices. *(Cont'd)…*		

Considerations	Recommendations	Standards	Impact
Communication (cont'd)	*(cont'd)* …Provide quarterly report on outreach efforts to providers. In the first 3 months of operation, the MCO will provide for weekly conference call capacity for all LTSS contracted providers and for the first 6 months will provide for Hotline support from 5-7, weekdays, for contracted providers.		
	MCO will also have qualified in state staff to act as Provider Services Manager who oversees staff to coordinate communications between the MCO and its Providers. There must be sufficient MCO Provider services, or equivalent department that addresses this function, staff to promptly resolve Provider Disputes, problems or inquiries.		
	Each MCO must establish a Provider Advisory Council to inform and receive feedback on policies and practices to assure quality and positive relations between the MCO and LTS providers.		

Considerations	Recommendations	Standards	Impact
Cultural competencies	Staff must also be adequately trained to understand Cultural, Linguistic, and Disability competencies.	In contract with State	Assures quality and serves all.
	Including Americans with Disabilities Act accessibility, communication and related standards.		
Infrastructure	The MCO must operate Provider service functions at a minimum during regular business hours (9:00 a.m. to 5:00 p.m., Monday through Friday). During the first six months of start-up, the MCO must provide extended call in service support with Hotline staff, between the hours of 5-7 p.m., to respond to calls or complaints by Providers.	In state Contract State monitoring	Quality

Considerations	Recommendations	Standards	Impact
Certification	The MCO may only include LTSS Providers in its Network that meet the minimum certification qualification requirements established by the Department. The MCO must credential LTSS Providers in accordance with the uniform credentialing framework provided by the Department. The MCO must comply with uniform credentialing and re-credentialing policies and procedures to ensure compliance with these specifications that meets the credentialing requirements outlined in the framework provided by the Department.	Contract and State rules	Quality
Incentives	Any MCO shall develop a Pay for Performance (P4P) Program, in year one, to provide financial incentives to Participants to remain eligible through redetermination or any other target area specific to systemic improvement that can be measured and in turn make MCO support provider payment bonuses.	In State contract	Improved system

Considerations	Recommendations	Standards	Impact
Penalties	If an MCO has not complied with the Claims Processing timeliness standards specific to HCBS Services/claims, the Department may separately impose sanctions to these claims types. CLAIMS ADJUDICATION REQUIREMENT (30 days, 60 days, and 90 days) to protect providers especially during the year one of transition to managed care.	In State contract	Accountability
Reimbursement	Reimbursements to providers must be timely within 30 days from submittal of claim.	In State contract State monitoring	Protect services
	Providers may charge interest on claims not received within said 30 days.		
	Reimbursement rates for services must reflect the need to build network capacity by supporting a livable wage for the services. Rates must also provide for the administrative cost for IT improvements, billing, rebilling, quality monitoring and training of direct service staff. *(See next slide…)*		

Considerations	Recommendations	Standards	Impact
Training	History of Medicaid and Long Term Services	In State contract	Quality
	Transition to Care Management differences from fee for services.	In State contract	Quality
	Credentials		
	The specifics being developed by other CFI sub group.		
	MIS and Xerox		
	Patient, Client, Consumer eligibility		
	Developed by other CFI workgroup		
	Referral		
	Role of Case Manager		
	Care Plan		
	Person centered		

Considerations	Recommendations	Standards	Impact
Training (cont'd)	Family and Guardian participation		
	Service deliver Scope being developed by CFI sub group		
	Cultural Rights of clients, consumers		
	Reimbursement for services		
	Payment process		
	Technology requirements		
	Standardized across all plans		
	Training needs to be prior to going live with mock claims		
	Denial of claim process and remedies		
	Provider appeal		
	Expedited procedure		
	Continuous review and improvement process.		

Considerations	Recommendations	Standards	Impact
Readiness	The two primary objectives at implementation is ensuring continuity of care for individuals already receiving LTSS at the time of implementation for CHOICES and continuity of payment for providers. (Members get services; Providers get paid).	In State contract State monitoring	Adequate service to NH residents
Phased in Implementation	To assure a smooth transition to Care Management, MCO's should develop a phase in plan geographically and by services. Each phase in plan shall provide the necessary resources to providers to support the additional administrative cost to managed care.	In State contract State rule	Prevent harm
	In year two of any MCO contract the MCO shall develop the necessary network to support participant directed services. (The delay in this service is necessary to assure the existing CFI services and network are implemented and operating effectively.)		

Quality/Outcomes/Transitions – Tina Paquin

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Ellen McCahon

Tina Paquin

Lisabritt Solsky

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Considerations	Recommendations	Standards	Impact
MEDICAL 1. Transportation for some LTSS Member on the CFI waiver requires support and assistance at pick up and drop off. 2. urgent transportation to Members and doctor appointments 3. Elders should have a consistent transportation provider with consistent driver.	• Door to door with hand to hand physical support be available as needed (members with dementia going to AMD services, for example) • Emergency Department discharge (not clear in current NH language) • Standing orders of rides (i.e. rides to Adult Day Care for 12 months, dialysis etc) • Transportation for emergent medical services *access to CTS during non-business hours to have ability to set up transportation needs.	**Transportation Compliance monitoring requirements should include the wait time for the ride (which is included in current reporting), but also include customer satisfaction and in year one, compliance with door to door, hand to hand, and standard for urgent transportation **the MCO should set wait time standards. A time standard example would be that the client arrives no more the 60 minutes early for appointment and waits no more than 60 minutes for ride home.	Decrease fall risk Increase safety for individuals traveling to and from medical appointments reduction of ED visits.

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TRANSPORTATION: NON-MEDICAL 1. Currently majority of CFI members have no access to community resources (grocery, banking, church, employment, etc) 2. Current CFI Waiver is cumbersome and therefore not utilized.	Steamline process and authorization Non-medical transportation should be expanded so that Personal Care Service workers can transport participants on errands other community outings. The definition of PSCP services should be expanded to allow the PCSP to be paid as a PSCP while transporting. CFI Waiver change.	**HE-E 801.21 Non-Medical **Transportation Compliance monitoring requirements should include the wait time for the ride (which is included in current reporting), but also include customer satisfaction and in year one, compliance with door to door, hand to hand, and standard for transportation.	
TRANSITIONS: 1. First year Fee for Service into MCO. 2. In concert with Gov outline of MLTSS services beginning 1/1/18 , initiate pilot to roll out phased incorporation of MCO by county.	No changes in authorized services without input of DHHS; Baseline Data for the first year; Look at workforce MCOs must have an adequate network of providers (How to keep current providers; How to increase providers where there are gaps) *(Cont'd…)*	Access to training support 7am-9pm for the 1st 90 days.	Increase knowledge of how MCO will work with LTSS; Should be minimal impact on services. **Cost to providers for possible new software; time for training **Lessen fear of new way to receive services. **All providers working to understand new business operations with MCO.

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	…(Cont'd) **CFI members remain eligible for Managed Care through the entire the month; current authorizations will be good with new Managed Care Agency for 60 days **Education of Members (How the new system will work; How transition into the new system will work); Education of Direct Support Providers (Billing process; Portal System; Authorizations) Education of ICM (Education on each Managed Care Agency and how to guide individuals; Authorizations education; Billing process; Portal System - timeline for training; How to support providers) **begin in high population areas--3 months then add new county.		
Quality Measures & Outcomes: 1. Ensuring an increase in quality of services. 2. Assure current service authorizations. 3. Satisfaction Surveys	Decrease in ED visits (Education of individual on when to use the ED; Other options to the ED such go to PCP or emergent care; When to push Emergency Response Button) Respite options. Turn around of Service Authorizations (Current: 72 hours for Emergency; 14 days for non emergency; Contract for 72 hours for Emergency; 7 days for non emergency). Authorized Care plans should anticipate circumstances where additional service hours may be needed (for example a caregiver is hospitalized, planned unavailability of caregiver (vacation etc) to support Right Service at Right Time. *(Cont'd…)*		

Considerations	Recommendations	Standards	Impact
	(Cont'd…) Complete member satisfaction survey yearly by independent party (for example Independent CM agencies) Satisfaction Surveys to include the following domains: home, social/ community, medical, rights, staff stability and competency, employment/volunteer, choice and decision making, Case Management.	**NCI **DHHS/ASPE **Truvin Health Analytics **CHCS July 2016 State Trends in Delivery of MLTSS	Overall cost savings. Decrease caregiver/family caregiver burnout. Right Service at Right Time (see recommendations for example). Increase duration of community tenure .
RATES AND PAYMENTS: 1. Assure rates of first year from fee for service to MCO. 2. Explore Value-Based Purchasing with LTSS providers.	**Rates remain at current levels for year one; **Determination of rates remain with DDHS ongoing; **MCO will phase in VBP model to reward quality services in MTLSS environment.	**State to continually review other border states to assure rate adequacy and benefits. **CHCS July 2016: State Trends in Delivery of MTLSS **Nursing facility VBP--QuILTSS (Tenn)	

Considerations	Recommendations	Standards	Impact
NETWORD ADEQUACY: 1. MCOs must have an adequate network of providers (How to keep current providers; 2. How to increase providers where there are gaps. 3. How to address unmet Behavioral Health needs.	*MCO will contract with any willing qualified provider. *All CFI rates need to increase. **Decrease unnecessary administrative burden of Kinship program and Adult Family Care. **Collaborate/alternate with MH and PCP to provide support. **Having Behavioral Health Social worker available to meet face to face in members home.	DHHS to survey at least yearly the boarder state rates	
Individuals need access to Conflict free Case Management:	Independent Case Management remain as a state plan service. Independent Case Management Agencies assigned for each individual. DHHS continues to assign Independent Case Management Agencies. Independent Case Management Agencies are to remain licensed entities.	Follow current ICM licensure regulations .	Assures Member choice. DHHS/ICM coordination of oversight member services.

Considerations	Recommendations	Standards	Impact

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